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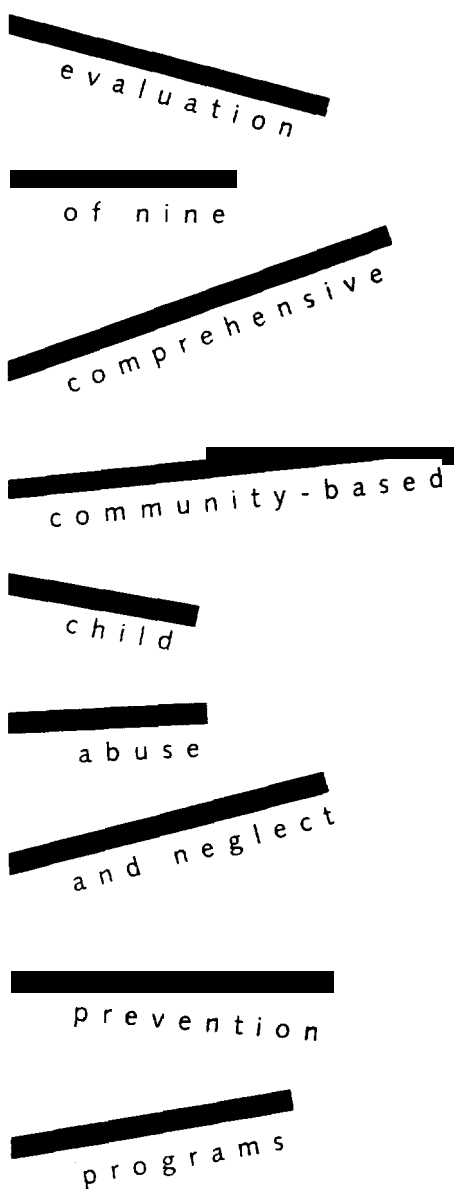
PREVENTING CHILD ABUSE AND NEGLECT

A Case Study of Families First in Fairfax



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PREFACE

The National Center on Child Abuse and Neglect (NCCAN) funded nine comprehensive community-based child abuse and neglect prevention projects in 1989. Through this 5-year grant program, NCCAN encouraged community groups, ranging from community-based organizations and child welfare agencies to universities and hospitals, to join together with other community forces to prevent physical child abuse and neglect. NCCAN underscored the intent that the projects were to be both community based and comprehensive-that they should network with and encourage the involvement of many community service providers.

The nine prevention projects represented diverse target communities, emphasized different objectives and approaches, and implemented different interventions in response to the NCCAN initiative. In choosing to fund such diverse projects, NCCAN sought to assess the effects of the different approaches based on the geographic, ethnic, demographic, and economic context of each community. The projects' approaches to preventing child abuse and neglect also reflected factors such as the philosophy of the project's architect, the project's history in the community, and requirements of other sources of funding. Thus, this grant program provided a singular opportunity for NCCAN and the prevention field to learn the strategies that worked best to focus community resources on preventing child maltreatment and the types of communities in which they worked best.

CSR, Incorporated, conducted a national evaluation of the nine prevention projects to document their experiences and contribute to an understanding of ways to mediate risk factors and strengthen families through solid partnerships with their communities. The evaluation included a series of in-depth site visits to each of the nine projects; analyses of project progress, evaluation, and final reports; and analyses of process and outcome data collected by the projects. In addition, information was obtained through meetings and conversations with project staff and through project publications such as manuals, newsletters, and program logs. Results of the evaluation are reported in the following:

- A set of nine case studies that reflect the uniqueness of each project and the complexity of their individual experiences;
- A cross-site analysis of the experiences of the nine projects, incorporating data collected by both CSR and the projects and presenting policy recommendations derived from CSR's findings;
- A "lessons learned" report discussing the most important findings and experiences of the projects.

The information presented in these case studies and reports' is intended to contribute to the effectiveness of prevention programs by highlighting how these nine communities established comprehensive projects for strengthening families and focusing community resources on preventing child maltreatment and by providing an understanding of what worked in those communities and why. As the prevention field increasingly recognizes that comprehensive and communitywide efforts are required to respond to the urgent problems that lead to child maltreatment, the experience of projects such as these will provide valuable lessons on which to build in policy and program development.

[1] Note that these case studies and reports primarily cover the base period of the NCCAN demonstration grant, which was 1989 through 1994.

FAMILIES FIRST IN FAIRFAX

This report describes Families First in Fairfax, one of nine demonstration projects funded by the National Center on Child Abuse and Neglect (NCCAN) to provide models of collaborative, community-based strategies for effectively preventing child maltreatment. Families First was developed by the Fairfax County (Virginia) Department of Human Development (DHD) to address the prevention needs of the county's diverse and growing multiethnic population, many of whom were recent immigrants and able to speak minimal or no English. As a comprehensive primary intervention model, Families First in Fairfax comprised the following three major components: (1) public awareness and community education, (2) early identification and intervention, and (3) crisis intervention. The program's goals included increasing the coordination of existing county services, reducing gaps in service provision, enhancing community awareness of the best practices in preventing physical child maltreatment, and increasing the sensitivity of the service provision to the multifaceted community.

Families First was designed to impact social service professionals; leaders of community organizations; and the high-risk population, including both teenage and new parents, substance abusers, school-age children, and victims and perpetrators of abuse. As evidence of its success in achieving effective, community-based strategies, Families First received an award in 1994 from the National Association of Cities/Counties for collaborative and innovative community-based programming and was twice the winner of the Fairfax County Volunteer Services Award for its innovative afterschool program and its Parent Nurturing Program (PNP). At the end of the Federal grant period, the most effective programs implemented by Families First were institutionalized into the county's Department of Human Development, Prevention Services.

THE FAIRFAX COMMUNITY

Fairfax County, in the Commonwealth of Virginia, is an urban yet scenic 399-square-mile area located across the Potomac River from Washington, D.C. It is composed of sprawling hills and housing developments and surrounded by national monuments and historic communities such as Old Town Alexandria and Arlington. In addition to being the most populated jurisdiction in the Commonwealth, Fairfax County has been growing rapidly, partly because of a significant influx of immigrants. Between 1980 and 1990, the total population in Fairfax County increased 37 percent, and the county's minority population increased 124 percent. Several distinct groups of minorities reside in the area, including Hispanics, Asian/ Pacific Islanders, and Middle Easterners, each of whom have their own language, culture, and social services needs.

As increased urbanization took place in Fairfax County, problems normally associated with urban areas also increased. Drug abuse became a major problem, and officials estimated that 10 percent of the total county population was addicted to at least one drug. Of those people who were addicted, only two-thirds sought treatment, while the other one-third went without assistance. In the late 1980s, the growing problem of drug abuse resulted in an increase in the number of births of drug-addicted babies, thereby creating an entirely new population of abused and neglected children.

Like other counties in the Washington, D.C., metropolitan area, Fairfax County has a very high median family income ($73,600 in 1990) as well as a large segment of its population living in poverty. Many Fairfax County residents who work full time are unable to afford the area's high cost of living. In particular, the high cost of housing severely limits the ability of many families to obtain and maintain a stable living environment. In low-income households with children, and especially single-parent households, affordable child care often poses an additional financial burden. At

times, families for whom child care is financially unaffordable may leave their children at home without adult supervision.

Due, in part, to its proximity to several military installations and to the Federal Government, Fairfax County has a highly mobile population. More than 36 percent of the population living in the county in 1988 were not living there 5 years earlier, suggesting that many residents lack the social support systems provided by extended families and long-term relationships. In addition to social isolation, some families (disproportionately minority families) face unemployment, lack of education, and poverty, all of which increase the stresses generally associated with domestic violence against spouses and children. According to Fairfax County's Child Protective Services (CPS), monthly investigations for child abuse and neglect increased 55 percent between 1981 and 1988.

When the demographics of Fairfax County began to change, several municipal agencies began offering additional programs to meet the needs of this diverse population. New groups serving and/or advocating for minorities were formed, changes were made in many existing programs, and new programs were developed to meet the growing need for drug abuse prevention and treatment. County agencies recognized, however, that many needs for assistance still existed. The identified needs included services for pregnant and parenting teens, adequate prenatal and postnatal care, prevention activities for school-age children, positive parenting classes, and substance abuse prevention and treatment. In addition, it was determined that the county's prevention services needed to be more accessible to minorities, especially those in non-English speaking groups.

GRANTEE ORGANIZATION: FAMILIES FIRST IN FAIRFAX

As previously mentioned, Families First in Fairfax was a program of Fairfax County's DHD. Four staff positions were added to DHD to operate Families First-a project coordinator, project facilitator, management analyst. and clerical support person. Near the beginning of the demonstration period, staff members were hired and received training in the dynamics of child abuse and neglect; cross-cultural training on Hispanic history, culture, customs, and client needs; and training in the dynamics of substance abuse. Additional training was provided later in cultural sensitivity to Middle Eastern populations. Staff members worked with the Citizens' Child Abuse Prevention Committee (CCAPC) to devise and implement various program activities and strategies. In addition to the four DHD Families First staff positions, in-kind support was provided to the program during the demonstration period through the formation of a Division of Prevention Services within the Department.

The Families First program coordinator handled rhe overall management of the demonstration project in close collaboration with other county social services agencies. The project facilitator assisted in all aspects of the program, with specific responsibility for assisting in planning and implementing family fairs, conducting community surveys, and developing programs for family resource centers. The management analyst coordinated the program's evaluation component, collected data on outcome measures for the National Committee for the Prevention of Child Abuse, and assisted minigrantees in their evaluation efforts.

In addition to using program staff, DHD contracted with a media consultant to assist in implementing the public awareness campaign, Northern Virginia Family Services to conduct the pilot stage of the Healthy Start program, and a part-time third-party evaluator to assist in analyzing data that would effectively evaluate the programmatic components of Families First.

As a program conducted within the Fairfax County infrastructure, Families First was affected by severe county agency budget cuts during the first year, which decreased all primary prevention programs in mental health, mental retardation, and alcohol and other drug (AOD) use services. While the

county's programmatic needs were increasing, budget cuts decreased the number of departments and agencies with which Families First was able to collaborate in service provision. During the second year of the Families First Program, the demonstration project underwent a structural shift from DHD's Office of Policy and Information Management to the newly created Prevention Division, which also resulted in the physical relocation of the program's offices to the DHD satellite office in Bailey's Crossroads.

PROGRAM DESIGN

Families First in Fairfax was a comprehensive, community-based child abuse and neglect prevention and early intervention program designed specifically to reach the county's diverse multiethnic population. The program was built on the principle of participatory prevention, and many strategies that were implemented were the direct result of communitywide collaboration. At its foundation, the Families First model emphasized the provision of services specifically tailored to clients' needs and conformity to the community's values. The model's implementation relied heavily on both formal and informal needs assessments, community input into planning and service delivery, group consensus and working agreements during planning, and interagency cooperation among service providers. Although the targets of many specific intervention strategies were three high-risk minority communities, Families First in Fairfax was intended to positively impact the county as a whole.

Implementation of the program benefited from Fairfax County's demonstrated commitment to combating child abuse and neglect. The groundwork for a comprehensive prevention program was laid in 1984, when the Fairfax County Board of Supervisors appointed a Child Abuse Prevention Task Force to examine the extent of child abuse in the county. The task force issued a report outlining recommendations for improving the county's response to the prevention and treatment of child abuse. A followup study issued 2 years later focused on improving the county's ability to respond comprehensively to child abuse issues as well as making recommendations regarding the organizations responsible for the multiple aspects of child abuse prevention.

In, 1988 the Board of Supervisors appointed a CCAPC to provide information to both the Board and the community-at-large about child abuse issues facing Fairfax County. The 23-member CCAPC represented various segments of the community, including local government; nonprofit organizations; the medical, ecumenical, and legal communities; the juvenile court system; the Fairfax County Public School Board; child care programs; parenting programs; the Private Industry Council; the Chamber of Commerce; United Way of Fairfax; the Commission for Women; and the Juvenile Court Citizen's Advisory Committee. Under the NCCAN funding, continuous efforts were made to expand CCAPC's scope of participation to ensure the widest possible collaboration in program development. Because it was already functioning and was based on the county's concern regarding child maltreatment, the CCAPC operated as an advisory committee for Families First in Fairfax and oversaw the planning, development, and implementation of the community prevention program. It continued in a primarily advisory capacity throughout the demonstration period.

At the beginning of the 5-year demonstration period, the Families First staff gathered information through both formal and informal needs assessments. Three countywide planning groups, composed of CCAPC members and other public- and private-sector representatives, were established to identify community needs and resources and to help implement strategies for filling service gaps. The planning groups focused on public awareness and community education, early identification and early intervention, and crisis intervention. The CCAPC also developed a strategic plan for advocating changes in the county's policy and funding streams to address the unmet needs. Community values and principles were identified through a series of focus groups and then

published in a volume titled *Matters of Principle and Practice*. To establish formal working relationships, the CCAPC introduced itself and its goals, the purpose of the demonstration grant, and *Matters of Principle and Practice* to both the Fairfax County Human Service Agencies Core Directors and the Citizens' Advisory Council.

The Families First model also was built on prevailing theories suggesting that the most effective method for preventing and reducing child abuse is through the active promotion of family and community well-being. Thus, the demonstration project emphasized changing the conditions under which child abuse and neglect are most likely to occur. The primary intervention strategies focused on promoting parenting education and competency, fostering collaboration between community organizations and systems interventions, increasing natural caregiving, and expanding consultation services.

Based on needs assessments, Families First selected three primarily minority-populated areas (Falls Church/Culmore, Route l/Gum Springs, and Herndon) as the target communities for the most intensive interventions. At that time, the centrally located Falls Church/Culmore area was home to the majority of Fairfax County's foreign-born residents. The Route l/Gum Springs community was predominantly African-American and accounted for the largest number of children entering the Fairfax County foster care system. The Herndon area had the county's fastest growing Hispanic community, and its needs were greater due to the population's low literacy rates in native languages, lack of English skills. and lack of jobs skills. Although these areas were diverse, they all had relatively large numbers of public assistance, child welfare, and social services cases.

To ensure solid grounding in the community, Families First in Fairfax created neighborhood coalitions to serve as liaisons between the CCAPC's planning committees and the particular target areas. Coalition members participated in identifying neighborhood needs, developing strategies to meet those needs, and implementing programs, specifically in relation to the family resource centers. To a great extent, the coalition members' specific responsibilities depended on the strategies identified through the CCAPC's planning committee process. Representatives from each neighborhood coalition were members of at least one planning committee.

One. of the surprising findings of the needs assessments was the common belief among community-based professionals that CPS was solely responsible for preventing child abuse and neglect. At that time, Fairfax County mental health providers, parent educators, crisis intervention service providers, and others regarded their services as treatment only and not preventive in nature. In addition, despite the eagerness of community professionals to become involved in prevention planning and service delivery, many agencies did not have the staff time or resources to afford prevention services. When resources became available, treatment programs were the first priority. In response, Families First directed some of its public awareness and community education efforts toward increasing understanding among community-based professionals about the components of a comprehensive prevention program and the necessity of focusing on prevention to decrease the incidence of child maltreatment.

The most significant gaps, according to the needs assessments, were in services for families who had multiple problems but were still capable of functioning in the community without mandatory interventions.

Public Awareness and Community Education

Public awareness and community education were essential components of Families First in Fairfax. The CCAPC planning group for these components comprised representatives from 16 Fairfax County agencies. The group developed a variety of community-based strategies targeted at various segments of the population, including ethnic language minorities, as well as the general public. A media consultant was hired to facilitate the

planning and implementation of a broad-based public awareness campaign. Families First also developed a general training and lecture series to provide information to community organizations and citizen's groups about child abuse and neglect and the demonstration project.

Over the course of the demonstration period, Families First generated considerable media attention. Articles about specific program components, events, and accomplishments were featured in numerous mass media and community-and issue-specific newsletters. The media attention also included features on several local cable television shows and an interview about the PNP by National Public Radio.

The program's public awareness and community education program components also included family events and strategies, publications and education packets, training and lecture programs, and Spanish-in-the-Workplace classes.

Family Events and *Strategies*

Several countywide family fairs were held to provide families with useful prevention and early intervention information as well as opportunities for positive family interaction. A wide range of workshops for parents and children was conducted by community agencies and organizations, and children were fingerprinted and photographed for easy identification in case of loss or abduction. The workshop topics included alternative and effective discipline techniques, ways to protect children against sexual abuse, substance abuse and child maltreatment, family nutrition, fire safety, and division of household responsibilities. One fair hosted a prevention-focused performance by a youth group and a puppet show on "safe" touch. Local businesses provided free food, movie and ice skating passes, and dinner coupons to promote additional fun family activities.

Neighborhood-based Back-to-School Nights were held to emphasize the importance of education and to encourage the parents' and community's involvement in the children's education. These events were planned and implemented by community residents. In addition to the parent–child activities, students received donated school supplies, which helped to sponsor the events as model community initiatives. With the success of the first Back-to-School Night, Families First discontinued the larger, more extensive family fairs and focused on neighborhood festivals. The neighborhood events were much less staff intensive, required less time and resources to plan and implement, and fostered greater participation by neighborhood residents.

Families First in Fairfax also hosted information booths at other events such as the Fairfax County Fair and the County Government Employee's Health Fair. The information booth at the Fairfax County Fair was located on "Children's Avenue" and was geared toward both parents and children. In addition to appearances by Spiderman. the staff sponsored interactive games for children, conducted a parent survey, and offered family information on preventing child abuse. The parent survey was useful in providing Families First with additional information on community awareness regarding child abuse and its prevention as well as in what prevention efforts community residents might be willing to participate.

Publications and Education Packets

The Families First program sponsored the translation into Korean of the Fairfax County handbook for families involved in domestic violence, which already had been demonstrated as useful. The publication provided basic information on what constitutes domestic violence, legal options for victims, and the availability of community resources for crisis intervention and treatment.

In collaboration with the local chapter of SCAN (Stop Child Abuse Now), Families First developed information packets for new parents and county day care centers. The "Welcome Baby" packet was designed for new parents who were delivering at area hospitals and contained information on infant care, community resources, and SCAN as

well as a set of Child Behavior Management Cards, which provided parenting education in an easy-to-read-and-understand format. Distribution of the packets was delayed because hospitals were reluctant to provide materials regarding child abuse to all new parents. The information packet developed for county day care centers included prevention information on child abuse and neglect, a list of community resources, information on both Families First and SCAN, and a handbook titled *Children-Our Greatest Resource.*

Families First also developed information packets on domestic violence that were provided to Fairfax County School personnel and DHD service staff. A workbook titled *I Wish the Hitting Would Stop* also was provided for use with children exposed to domestic violence.

As a public awareness tool, the program developed a 6-minute videotape about Families First in Fairfax, which was to be used in community and interagency presentations. The videotape provided an overview of the prograin's key components and was made available throughout the county. It was shown frequently at a variety of community and agency meetings and on the local cable television station.

Training and Lecture Programs

Families First provided a wide variety of training programs on prevention and child maltreatment issues during the demonstration period. These included panel presentations for school personnel and for the staffs of day care centers on "Stresses in Families," multidisciplinary training for community social services professionals, an in-service presentation to Virginia Power employees on what constitutes abuse and neglect, and training sessions for community service professionals on teenage pregnancy.

Spanish Classes

To facilitate all aspects of the Families First program, Spanish-in-the-Workplace language classes were provided for DHD caseworkers, public health nurses, and other community facilitators who worked with the public to better serve non-English-speaking clients. (Approximately 40 percent of the clients served by the Fairfax County Health Department and 60 percent served by the Fairfax County DHD Falls Church office are nqn-English-speaking.) This program was a collaborative effort between DHD, the Office of Personnel, and Fairfax County Public Schools and was thought to be a successful way of expanding the outreach capacity of prevention and early intervention services agencies.

Early Identification and Early Intervention

The Early Identification and Early Intervention planning group was responsible for developing the county's resources to include opportunities and programs for families that would help prevent them from abusing and neglecting their children. Through collaborations made possible by the planning group, Families First implemented a PNP and three family resource centers. The planning group also was instrumental in identifying the need to recruit and retain Hispanic child care providers who could provide services during nontraditional work hours.

Parent Nurturing Program

The PNP was implemented primarily for parents who were receiving services from a Fairfax County agency and who were identified as either abusing or neglecting their children or at risk of doing so. Families First chose the well-known and highly regarded PNP, created by Stephen Bavolek, to operate as both a primary intervention and as a treatment program for improving dysfunctional and abusive parent-child interactions. Eligibility for participation in one of the PNP courses included the parents' commitment to attend the entire program and mandatory attendance at the first four sessions to facilitate development of the group process.

Based on general agreement that parenting is learned, the major goals of the PNP are to increase parents' knowledge of appropriate child

development and needs; increase empathy for and awareness of others' needs; increase positive self-concept and self-esteem in all family members; and teach parents alternatives to hitting, spanking, and yelling at their children. In addition, the program seeks to increase family communication and expressiveness and to build family support and cohesion. The PNP sessions address the parents' need for nurturing and for "re-parenting" their children. Concurrent nurturing learning experiences are provided for the children.

During the demonstration period, Families First provided multiple sessions of four of the PNP courses in five different locations in Fairfax County. These included (1) 23-week sessions for parents and children from birth to age 5, (2) 15-week sessions for parents and children ages 4 to 12 years, (3) 12-week sessions for parents and adolescents, and (4) 6-week sessions for parents and their children who were entering kindergarten. Although the PNPs were open to the public, most participants were referred by DHD programs, including CPS, Transitional Housing, Foster Care Services, and Family Services. One-third were ordered to participate by the Juvenile and Domestic Relations District Court.

Initially, 150 Fairfax County professionals were trained to conduct the PNP courses during training sessions conducted by the program's creator. Over the course of the demonstration period, the sessions were increasingly conducted by community volunteers who were trained by members of the Families First staff, although the majority of session leaders continued to be county staff. In addition to reducing the cost of this program component, the use of community volunteers made the program more community based. The PNPs also benefited from the participation of student interns, who assisted the PNP coordinator in operating the program.

Healthy Families Fairfax/Healthy Start Program

The Healthy Families Fairfax/Healthy Start program was a home-based, early intervention program that focused on advancing children's physical development during early childhood as well as preventing child abuse and neglect by enhancing parent-child interaction and promoting parents' problemsolving skills. This intervention was based on two decades of research indicating that home-based education and support provided around the time of birth is the single most effective strategy for preventing infant and child maltreatment.

The Healthy Families Fairfax/Healthy Start program originally was implemented, through a contract with Northern Virginia Family Services, as a pilot study focused on Hispanic families with children from birth to age 3. The target population was selected based on the county's multicultural needs assessments. During the pilot stage, families were recruited through a two-stage screening of all mothers giving birth at participating hospitals. The screenings were designed to locate the potential for abuse due to psychological or situational stress factors. Families considered eligible for the program were offered services on a voluntary basis by the program's paraprofessionals.

At the end of the demonstration period, the program was institutionalized into the Fairfax County Department of Family Services and the Fairfax County Health Department, at which time the program's name was changed from Healthy Start to Healthy Families Fairfax. The program shifted into the county agency to allow for its stabilization as well as its expansion to all first-time mothers residing within target communities who had no severe psychological disorders or severe learning disabilities.

Families receiving Healthy Families Fairfax/Healthy Start services were provided with home-based instruction in child development, home safety, well-baby care, and problemsolving skills Participating families received transportation to medical services, crisis intervention, informal role modeling, and referral to additional community resources, including identification with a regular health care provider. The home-based family support services were provided by a bilingual staff consisting of family support workers, an early

identification worker, a student nurse, and a project coordinator who had received specialized training provided by the Hawaii Healthy Start training team. The frequency of visits was based on the clients' needs. Home visits were conducted weekly at the beginning of the program and reduced to quarterly visits by the end of the program.

Parents participating in the Healthy Families Fairfax/Healthy Start program were eligible to take part in parent education groups led by the family support workers. The parent education groups used the "Dance With the Baby" curriculum, which taught positive and effective ways to interact with infants from birth to age 6 months, and the "Nueva Familia" curriculum, covering birth to 2 years. Large group events also were arranged (e.g., community potluck picnics) for the participants to decrease parental isolation and provide informal opportunities for positive parent-child interaction.

Family Resource Centers

Most Families First family support services for at-risk parents and children were conducted through three family resource centers implemented in collaboration with the Fairfax County Housing and Community Redevelopment Authority and the Fairfax County Police Department. The Westford, Cuimore, and Franconia family resource centers were located in high-risk neighborhoods, among the residences of the target population, and were easily accessible on foot. Each center was staffed by culturally competent personnel, and the programs and services provided were tailored to the needs of the specific community being served. Services included information, referrals, social activities, and support services to strengthen families and, ultimately, prevent child abuse and neglect.

The family resource centers provided families with direct access to parenting education, information about human development, and self-esteem and skillbuilding activities in a nonthreatening, community-based setting. Neighborhood coalitions provided input for the development of the programs offered at each site, some of which were organized and conducted by the residents themselves. Volunteers from various disciplines offered screenings, such as health and dental screenings, at the resource centers. The wide-ranging activities at the centers included family fairs anci block parties, youth groups and recreational opportunities, academic tutoring, and support groups. Two centers operated in collaboration with the Police Department and had officers on site. The officers responded to all calls from the community, initiated Neighborhood Watch programs; and provided preventive community policing.

Neighborhood Organizations to Alleviate Homelessness

Developed late in the 5-year demonstration period. the Neighborhood Organizations to Alleviate Homelessness (NOAH) prevention services component was implemented as an early intervention program to prevent homelessness among at-risk families. While this program was not part of the NCCAN demonstration project, it was clearly an outgrowth of the program's emphasis on prevention that began to permeate the county as a result of Families First in Fairfax. NOAH was funded through a grant from the U.S. Department of Health and Human Services to research, design, and implement a case management model for the prevention of homeiessness. It was added to the Department of Prevention Services in late 1993 as a 3-year pilot project for 50 families through the Culmore Family Resource Center. NOAH was designed and developed through the same process used by Families First and provided a combination of rent assistance and comprehensive case management services to families before they lost their housing. The intent of the program was to stimulate community collaborations and make services more accessible to families.

Other Initiatives

As part of its coordination efforts with other county prevention organizations, Families First in Fairfax initiated discussions with the county's Special Needs Parenting Committee to increase the availability of services for developmentally delayed, mentally retarded, and low-functioning parents who were in need of developing their ability to parent. A model also was developed in collaboration with the Respite Care Committee to provide a respite care program for children with special needs or who were medical technology assisted as well as for children whose parents were overstressed.

In addition, Families First sponsored a countywide Prevention/Early Intervention Information Exchange Forum during the program's fourth year to convene representatives of a broad range of social services agencies and to increase the level of collaboration and information sharing among them.

Crisis intervention

Early in the demonstration period, the Crisis Intervention Planning Committee reviewed the availability of crisis intervention services for Fairfax County children and families who had experienced abuse and neglect. The members of this committee included CPS staff, members of the Police Department's Criminal Investigations Bureau, and training staff at the National Children's Hospital. The committee identified the need for a comprehensive, emergency medical diagnostic and treatment service for children suspected of being physically or sexually abused.

Families First created a medical team composed of Fairfax County physicians who provided medical examinations on an "on-call" basis. The physicians received intensive training in identifying and detecting physical and sexual abuse, the emotional impact on children who have experienced abuse, and the physician's role in the criminal and civil legal processes to protect children suspected of having been abused. The training was performed by Children's Hospital Center staff in cooperation with the Police Department's Central Intelligence Bureau (i.e., the police department staff who assist in investigations) and the CPS staff. The physicians who served in this capacity were formally known as the Physicians Trauma Team, which was later renamed the Child Abuse Trauma Team.

Physicians were recruited for the Child Abuse Trauma Team through presentations conducted by Families First staff at Fairfax Hospital. After being screened and trained, team members were on call 24 hours per day in response to Fairfax County police investigators and CPS staff to examine children alleged to have been abused or neglected. The examinations were conducted in the doctors' private offices rather than in the high-pressure environment of the hospital emergency room, unless the presenting medical condition warranted a hospital visit.

During the final years of the grant, the focus on crisis intervention services all but ceased so that Families First could focus more heavily on the early identification/early intervention and the public awareness and community education components of the program.

Minigrant Community Initiative

The Minigrant Community Initiative was created during Year 4 of the demonstration period to encourage development of innovative, grassroots programs in Fairfax County to strengthen families and reduce the incidences of child abuse and neglect. Small grants of up to $2,000 were provided to community organizations and agencies as seed money for implementing family support efforts that included parenting programs, outreach to high-risk populations, anger management workshops, a hotline for families, homework centers, a tenant empowerment program, and early identification/early intervention services.

Families First conducted two minigrant cycles during Years 4 and 5, and approximately 10 programs received funding each cycle. During the second year of the minigrant program, contract

awards were increased from $2,000 to $2,500 as a direct result of feedback received from previous minigrant recipients. In addition to the minigrants. Families First provided technical assistance to the minigrantee agencies to help them evaluate their community-based prevention efforts.

COMMUNITY COLLABORATION AND LINKAGES

Throughout the demonstration period, many public and private partnerships were formed to successfully implement Families First's prevention and early intervention program goals. As previously mentioned, the organizations were involved in every phase of the program's planning, implementation, and evaluation. Much of this planning and implementation was accomplished through the CCAPC, Families First's advisory committee, and its countywide planning committees.

The service delivery of many of Families First's program components directly resulted from the linkages and relationships formed through interagency coalitions and service networks. Several larger service delivery collaborations included the minority-population needs assessments and initial implementation of the Healthy Start program with Northern Virginia Family Services; the development and coordination of the family resource centers with Fairfax County's Public Housing Authority and Police Department; the development and distribution of "Welcome Baby" and the day care providers' packets with SCAN; and the collaboration with Children's Hospital Center, the Police Department, and CPS to implement the Physicians Trauma Team. The family fairs consisted of multiple organizational collaborations, and the Back-to-School Nights were conducted in collaboration with the Fairfax County Public Housing Authority and the schools in which they were conducted.'

Families First staff also served on numerous countywide coalitions, committees, and task forces to spreadwatch information about the demonstration project and to facilitate working relationships with other family support programs. Some organizations with which they worked included the Domestic Violence Coalition, SCAN, and the local chapter of the National Committee for the Prevention of Child Abuse. The program staff also attended local, regional, and national conferences on substance abuse, teenage pregnancy and parenting, domestic violence, and other relevant topics. Families First sponsored the use of three Child Behavior Management Cards published by the Ohio Research Institute on Child Abuse and Neglect, another one of the nine demonstration projects funded by NCCAN.

PROGRAM EVALUATION

Although Families First in Fairfax was responsible for developing and implementing numerous prevention and early intervention strategies during the demonstration period, the formal evaluation focused on the implementation and outcomes of its three primary programs-the PNPs, Healthy Families Fairfax/Healthy Start, and the three family resource centers. In Year 4, NCCAN made funding available for evaluation, and an independent evaluator was hired to conduct a systematic and comprehensive evaluation of the three programs for use by NCCAN and others to evaluate the effectiveness of community-based prevention strategies among diverse populations. Families First provided informal evaluations of other aspects of the demonstration project, and Northern Virginia Family Services gathered data to examine the pilot stage of the Healthy Families Fairfax/Healthy Start program.

The framework of the independent evaluation of Families First in Fairfax consisted of an assessment of program implementation and outcomes; assessment of client outcomes; and implications for future programs. Because a formal data management system did not exist for any of the programs and the independent evaluator was hired late in the demonstration period, the data available for analysis were limited and were neither systematic nor complete. In addition, the program models were never fully delineated, nor were goals

and objectives formally outlined. This forced the independent evaluator to impose the same conceptual framework for each program and to use staff report summaries to supplement the available data when conducting the evaluation.

The data collection methods used in evaluating Families First in Fairfax included structured and semistructured interviews, reviews of archival records, observations of program activities; questionnaires; and case studies.

The tasks involved in evaluating the three programs included determining appropriate research and evaluation designs, establishing research questions and hypotheses, reviewing and assessing the status of existing program data, creating new data collection instruments and data entry programs, training in and monitoring of data entry procedures, and conducting statistical analyses.

The evaluation of the PNPs used the following case management and outcome data collection instruments:

- Client referral form;
- Client Identifying and Referral Extraction Form (CREF);
- Family Social History Questionnaire, which used a separate form for teenage parents;
- Nurturing Quiz, which used separate versions for parents and adolescents, parents and children ages 4 to 12, and parents and children from birth to age 5;
- Adult-Adolescent Parenting Inventory (in both pretest and posttest versions);
- Family log;
- Program evaluation form; and
- Child Abuse Potential Inventory.

The evaluation of the Healthy Families Fairfax/Healthy Start project examined both the pilot program and the beginnings of the broader. institutionalized program. Data were collected using the following instruments:

- Local case management forms, including Phase II Screening Form, a Referral Activity Record, a Client Service Record, an Individual Family Support Plan, a Client Service Log, and an FSW Monthly Summary Sheet;
- DENVER II Development Assessment Instrument;
- Nursing Child Assessment Satellite Training (NCAST) Difficult Life Circumstances Scale;
- NCAST Community Life Skills Scale;
- NCAST Network Survey;
- Family Stress Checklist; and
- Hawaii Healthy Start Program Level Changes.

The evaluation of the family resources centers was conducted individually. The following data collection instruments were used when available (not all three centers used all the data collection instruments):

- Daily sign-in sheets;
- Drop-in tracking forms;
- Special event surveys; and
- Community Policing Impact Evaluation Survey.

In addition, the formal evaluation addressed the following research questions for each program, as applicable:

1. Was the program implemented as planned?
   a. What barriers/obstacles impeded program implementation?
   b. What facilitators/factors enhanced program implementation?

3. What were the characteristics of the clients **served** by the program?

3, To what extent were at-risk families identified? For the family resource centers: What were the family and individual needs, services provided, and services utilized by the family resource center clients?

4. For whom (e.g., client characteristics) was the program most and least effective?
   For the family resource centers: What was the level of community involvement in the family resource center?

5. For which program types (e.g., age groups) was the program most and least effective?

No attempts were made to collect preprogram and postprogram data on community indicators to determine any communitywide impact resulting from Families First prevention strategies.

Technical Assistance

CSR provided technical assistance to Families First in Fairfax with the specific intent of increasing its ability to conduct an effective evaluation. Because the focus of each NCCAN grantee's demonstration project was to mobilize community-available resources to improve community conditions that place children at risk of child abuse and neglect, Families First was advised to establish a systematic method for documenting its activities, noting dates for developing a chronology of events, to facilitate the implementation/process evaluation. In addition, it was recommended that contacts with other organizations and individuals who were connected with the family resource centers be described to document agency collaborations and community involvement.

For the family resource centers, in particular, CSR recommended specific procedures for collecting information that could be used for the outcome evaluation, as follows:

- Determine the nature and frequency of resource center attendance by **various** categories of people with daily sign-in sheets; the same form should be used at all three sites. Existrng procedures could be streamlined by using the existing Random Sample Information Sheet for the family resource centers to develop profiles of regular center users. This form provides information on referrals, service utilization, and demographics for randomly selected center participants.

- Go beyond random selection (even though this raises sampling difficulties) and develop simple records for regular participants that contain standard types of data. This would provide a profile for each participant, with an identification (ID) number, so that information could be gathered over the course of regular activities without using potentially intimidating interviews or self-administered participant questionnaires. This process could be easily facilitated by issuing membership ID cards, which participants in other programs have been happy to have, and by facilitating recordkeeping at each resource center.

Technical assistance also focused on helping the DI-ID conduct its own internal evaluation of Families First. Suggestions were provided regarding data collection systems and data analysis to help systematize and enhance existing efforts. In addition, Families First was encouraged to preserve and assemble internal documents such as memoranda, reports, and agreements that would help to describe the program's workings. It was recommended that the program solicit and record observations of the staff, participants, and others involved with the program as qualitative data that would help track community and collaborative changes and issues over the life of the program.

CSR also assisted Families First in identifying information on how Fairfax County community, agency, and government resources were mobilized to prevent child abuse and to enable the organization to provide information for the cross-site evaluation of the nine models in the NCCAN

demonstration project. Because Families First offices were in close proximity to CSR's Washington, D.C., headquarters office, this technical assistance was readily available. CSR also offered to assist the program with advanced computer analyses of data using CSR's extensive computer facilities.

FINDINGS

As with many model community-based programs, the program being operated in Fairfax County at the end of the demonstration period differed extensively from the program outlined in the original grant proposal submitted to NCCAN. During the first 2 years, Families First in Fairfax undertook a number of child abuse prevention strategies, many of which were ultimately discontinued. The greatest barrier to overall program implementation at that time was a lack of specificity on how to achieve the program's mission. The program's last 2 years, however, were extremely fruitful in terms of program development. Most of the strategies developed during those later years were quite effective and were institutionalized into existing county departments and agencies at the end of the demonstration period.

The implementation of Families First in Fairfax strengthened the county's ability to recognize the importance of family support systems in the prevention of child abuse and neglect and to take positive steps toward putting those family support systems in place. The growth in parenting programs, family and early infant health care programs, neighborhood-based resource centers, and directories of services made available to ethnic minority populations contributed significantly to Fairfax County's demonstrated commitment to child maltreatment prevention. In addition, increased collaboration and information sharing occurred among the agencies and organizations working with at-risk children and families during the course of the demonstration project and continues, even though the project has ended.

Over the j-year demonstration period, one of Families First's biggest problems was numerous leadership changes. Staff turnover affected all positions except that of the management analyst. The impact of these turnovers was reflected in the inconsistency in program activities and, perhaps, in the inability of the program to create and implement additional strategies that could have served more families.

Public Awareness and Community Education

The public awareness and community education components of Families First were not formally evaluated. The demonstration project, however, was able to document its considerable efforts to provide child abuse and neglect information to the public as well as increase knowledge among community social services professionals on the best early identification and early intervention practices. Estimates indicate that the Families First public awareness and community education strategies reached more than 800,000 people in Fairfax County. This estimate includes audiences for specific training programs, audiences for both the cable television programs and the repeat showings of the program's videotape, and the readership of the numerous newspaper and newsletter articles published on Families First in Fairfax.

Early Identification and Early Intervention

The goals of the early identification and early intervention components of Families First were as follows:

- Reduce gaps in services;
- Develop more positive working relationships among agencies, police, and the courts;
- Increase services as well as cultural sensitivity to meet the needs of the diverse population;
- Improve maternal and child health measures, such as the incidence of low-birthweight babies; and

- Reduce the child abuse and recidivism rates.

The most focused and substantial efforts to achieve these goals were the PNP, the Healthy Families Fairfax/Healthy Start program, and the family resource centers. An independent evaluator measured the demonstration project's success at meeting these goals. The results of this third-party evaluation are listed below.

Parent Nurturing Program

Although the data were poor due to collection problems and small sample sizes (out of a cohort of 180 program participants, valid pretests and posttests were completed by 54 parents for the Nurturing Quiz, 80 for the Adult-Adolescent Parenting Inventory, and 4 for the Child Abuse Potential Inventory), the PNP evaluation provided some interesting information on the effectiveness of this type of intervention. In general, the data suggest that'although the participants were provided with alternative child behavior management techniques in the PNP sessions, their attitudes and beliefs were not significantly enhanced as a result of their participation. This may be accounted for by the fact that approximately two-thirds of the participants scored below risk level on a self-reporting scale measuring parents' beliefs linked to abusive and neglecting behaviors indicating that the PNP may not be serving an "at-risk" population. The parents reported that PNP participation changed their lives, particularly by encouraging self-growth and development. By feeling better about themselves, they also felt better about their children and about being parents.

Several other interesting insights emerged from the data analyses. Although the results of differential effects based on client characteristics were insignificant (as in the case of gender) or were not achieved due to lack of sufficient data (e.g., on age, race/ethnicity, or socioeconomic status), the analysis of program type suggested that participants in the PNP sessions for parents with children ages 4 to 12 significantly increased their knowledge of appropriate behavior management strategies, whereas participants in the sessions for parents with children from birth to age 5 did not. This finding has implications for future programming; however, it must be noted again that the results are from sample sizes too small to be statistically significant. In addition, although the demonstration project's goal was to serve primarily the county's ethnic minorities, 47 percent of the PNP participants were Caucasian. Because most PNP participation resulted from referral by other social services agencies, the ethnic composition has implications beyond that of Families First.

The qualitative evaluation of the Families First PNP reveals strong client enthusiasm for the courses, a high level of staff commitment, and notable (community involvement. In addition to providing the community with strong family support and parenting skills enhancement, the PNPs offered learning experiences for student interns and volunteer opportunities for community participants. The increased community participation benefited Families First by lowering costs and decreasing staffing requirements.

Healthy Families Fairfax/Healthy Start Program

The process evaluation of the Healthy Families Fairfax/Healthy Start program suggests that during the pilot stage, the Healthy Start program was able to provide regular, home-based family support services for 47 to 57 Hispanic families, with an 18-percent attrition rate that can be attributed primarily to the high mobility of the target population. Due to staffing problems within the contracting agency (i.e., Northern Virginia Family Services), however, the program was suspended and home visitations were discontinued for approximately 6 months (from July 1993 to January 1994). When the program was institutionalized in February 1994, services were reinstated to the remaining original program participants and were expanded to additional at-risk families in the county with newborns.

The major barrier to operating this program as a pilot with the contracting agency, according to the

Northern Virginia Family Services program coordinator, was the lack of adequate funding. The pilot program also suffered from the fact that as an "appendage" to DHD's Prevention Unit, the program was not officially sanctioned as a county program. Additional barriers to its implementation and effectiveness included the lack of a steering committee, job insecurity among staff members in the contracting agency, and a lack of coordination between program staff, who were actually employed by Northern Virginia Family Services, and the staff of Families First. Staff interviews revealed that the Healthy Families program also was hampered by the lack of coordination between the county's mental health, child care, and transportation services.

For various reasons, including the program's temporary suspension, many of the regularly scheduled assessments of the pilot program participants were not completed. Famiiy stress baseline measures suggest, however, that most participating families were of moderate to high risk for substantial chronic problems or stressors in the family. In addition, the baseline data for the participants' level of self-sufficiency indicated that 43 percent were at high risk for inability to use community resources, such as transportation and support services.

The outcome evaluation of the Healthy Start pilot program suggests that it was effective in reducing the rate of recidivism among participants who had previous reports of child maltreatment. Of the four cases with previous CPS reports, 100 percent were not subsequently reported either 1 or 2 years after entry into the program. Among the other participants, 8.5 percent were reported for child maltreatment after 1 year, and 8.5 percent of participants were reported for child maltreatment after 2 years. (Those families with reported incidents after 1 year were not the same families with reported incidents after 2 years.) These rates were not compared with those of the general population or to a comparison group, so it is not known whether they were relatively high or low.

The effect of the Healthy Start pilot program on parent-child interaction was not assessed, because the intended **data** were not collected. Data collected at 6-, 12-, 18-, and 24-month assessments revealed that the participating children increasingly fell within the normal developmental profile over the course of the program (from 77 percent at 6 months to 100 percent at 24 months). These **data** were not compared, however, to the general population or to a comparison group within Fairfax County to determine what portion, if any, of this increasingly normal development could be attributed to program participation. In addition, only 20 percent of 47 Healthy Start clients had timely and up-to-date outcome assessments.

In evaluating whether the Healthy Start pilot program enhanced the participating parents' problemsolving or life skills, the data suggest that participating mothers had slightly lower levels of life stressors after 12 months of participation and significantly lower levels after 24 months. Participating mothers also had significantly higher levels of self-sufficiency after 24 months.

Generally speaking, the pilot stage of the Healthy Families Fairfax/Healthy Start program should be considered a learning phase. The program's second phase was designed to allow for stabilizing service provision (and data collection) as well as expansion to a more diverse client population within the geographically defined service area. Preliminary findings of the second phase suggest that about one-fourth of the new participants scored at risk for life stressors and degree of self-sufficiency, and two-thirds had elevated scores for risk of physical child abuse. This difference probably reflects the increased diversity of program participants, which resulted from the decreased emphasis on recent immigrants and non-English-speaking people.

Family Resource Centers

The process evaluation of the three family resource centers, which were opened at different times during the demonstration period, provided interesting insights into the dynamics of this

component. Overall, the program models at the end of the grant period represented an expansion of each center's original design. Specifically, each center expanded its staff resources to include alcohol and other drug service (ADS) counselors, community volunteers, and student interns. These additions provided two advantages over the original program model: (1) the use of community volunteers was cost-effective and made each family resource center more neighborhood based and (2) the addition of the ADS counselors allowed Families First to address the common coexistence of substance abuse and child maltreatment, which the program did not initially address.

Data collected at the resource centers during the grant period consisted mainly of recruitment data (e.g., number of drop-in visitors), the numbers of programs offered, and the number of collaborative relationships involved in programming. Only a limited amount of data were collected on service characteristics, such as the types of support services that were both needed and used by drop-in clients. Thus, it was difficult to evaluate either the intensity or scope of services offered or the effect of the formal programs on individual participants. Thus, the effectiveness of the family resource centers in preventing or reducing child maltreatment could not be assessed.

At each of the family resource centers, the number of adult visitors increased significantly (the median monthly adult visitor rate increased from 15.5 to 64.0 at the Westford Center and from 3 1 .O to 120.0 at the Culmore Center; no visitor data were collected at the Franconia Center) during the time they were in operation, with the point of increase occurring approximately 1 year after the centers opened. This coincided with the facilitators' description of the first year of program operations as being a planning phase during which program ideas were developed and piloted. The visitation rate of children at the Westford Center started high and increased 22.3 percent over the 2 years of operation, whereas the rate of child visitation at the Culmore Center started low and increased 418.7 percent between the first and second program years. Only some of the difference in the increase of child participation can be attributed to targeted programming.

Each farnily resource center provided referrals to existing county programs and services as well as to programs developed specifically to meet the needs and requests of neighborhood residents. The programs developed and implemented at the family resource centers included academic support, such as tutoring and homework groups; recreation; instructional programming, such as the PNPs; community development, including Neighborhood Watch; and both health-related and emotional support.

The primary barrier to implementing the family resource centers was the initial difficulty in attracting community residents. This was less of a problem at the Westford Family Resource Center, because the primary staff person was well known within the target community and had an exuberant and nurturing personality that tended to draw people into the center to find out what services were available. In each of the communities served, the necessary first step was building trust among the neighborhood residents. The largely new immigrant population in the Franconia area, in particular, required considerable time for trust building. Near the end of the demonstration period, all three resource centers were receiving increased numbers of resident referrals and some centers even began receiving donations from community members. Outreach was conducted door-to-door and by offering programs specifically targeted toward neighborhood females. Another problem common to the resource centers was data collection, which was most frequently conducted through the drop-in visitors' registration form. The form was time consuming to complete on a daily basils, which led to retrospective completion with estimated numbers.

According to program staff, the factors that facilitated the implementation of the family resource centers included the enthusiasm of the volunteer staff members; the strong collaborative relationships that produced many of the centers' programs; the broad dissemination of information

about the centers' programs; and the centers' welcoming environment where neighborhood residents could relax, have coffee and snacks, and have access to culturally relevant family-focused reading materials.

In addition, staff felt that the partnership with the Police Department at two of the centers was a strength for both the centers' staff and neighborhood residents. The presence of the police officers helped prevent outbreaks of violence at the resource centers. However, other Fairfax social services workers noted that many Hispanic communities generally are uncomfortable with a police presence and, therefore, may have avoided activities at those resource centers.

Interviews with staff members highlighted the following lessons learned:

- The nontraditional hours required of the staff drained their energy, and the lack of overtime pay meant that additional hours had to be flexed from the staff's already full schedules;
- An ever-present undercurrent of danger existed in the neighborhoods in which the centers were located, posed by the presence of armed gang members and the pressures created by the high population density;
- The activities and programs at the centers were more successful when the neighborhood residents were involved in the initial planning;
- Programs should be evaluated continually and changes made as needed to maintain resident involvement; and
- It is important to involve the schools early and often.

Problems mentioned by the staff included the following:

- "Turf issues" made collaboration among agency partners difficult;
- There are no perfect prevention or family support methods that will always work well in a challenged community; and
- It was difficult to work with a group that had no plan of action and with people who were often unmotivated. (Regarding the "lack of motivation" mentioned by program staff, other Fairfax social services workers pointed out that clients may have appeared unmotivated because of the staffs incorrect perceptions of clients' needs.)

Crisis Intervention

Because Families First in Fairfax was primarily a prevention/early intervention program, much less attention was focused on developing or coordinating crisis intervention strategies. The development and implementation of the Child Abuse Trauma Team early in the demonstration period was the exception. Through collaborative agreements, Families First successfully recruited six doctors to constitute the Child Abuse Trauma Team. Beginning in May 1991, these physicians were on call 24 hours per day to conduct medical examinations of children suspected of being either physically or sexually abused. By September 1992, 32 children had been examined by a member of the Trauma Team. After implementing this crisis intervention component, Families First ceased its involvement in this program.

Minigrant Community Initiative

Although the Minigrant Community Initiative was developed late in the demonstration period, Families First considered it a successful method for developing community-based prevention strategies. Over two grant cycles, the minigrant initiative provided 19 minigrant awards of $2,000 to $2,500 each to 14 Fairfax County organizations for conducting prevention and early intervention programs that strengthened children, youth, and families. A conservative estimate is that these initiatives reached more than 650 county families

Several important lessons were learned from this program component. Its slow implementation was attributable primarily to requirements related to Fairfax County government procurement regulations. Although initial problems were overcome, the county's request-for-proposal process continued to make it difficult to expedite front-end funding to the grantees. On the positive side, the Minigrant Initiative required minimal staffing, had low administrative costs, facilitated grassroots outreach, and fostered community-based program development. According to Families First, the Minigrant Initiative fostered 73 collaborative partnerships with community-based human services organizations, civic groups, and private industry.

It is expected that the minigrant program will be continued in Fairfax County through family support/family preservation money available from both Federal and State governmental agencies.

General Hindrances

As with many collaborative ventures, Families First encountered some philosophical differences among county agencies that affected implementation strategies and program components. For example, agencies differed on how to effectively address alcohol and drug abuse within the target communities. In addition, several schools did not want to participate in a child abuse poster contest, and at least one hospital was unwilling to participate in the general distribution of "Welcome New Baby" packets that contained references to child abuse prevention.

There also were difficulties in carrying out prevention work within a social services department. For example, although the Healthy Families Fairfax/Healthy Start program achieved most of its program objectives, the bureaucracy and staff and funding limitations limited the full evaluation of the program. The Healthy Start mode1 recommends monitoring child protective statistics on program participants to assess the program's effectiveness in preventing child abuse and neglect. Northern Virginia Family Services, the community-based nonprofit organization that conducted the pilot program, did not obtain this information from CPS because confidentiality releases could not be negotiated. The lack of a concrete agreement with CPS for obtaining statistics with which to compare county population rates hindered the program's ability to determine the program's effectiveness among the target population.

Additional barriers included the lack of available child care and transportation to help parents attend parenting; education classes, the lack of acceptance of Families First by some established nonprofit social services organizations and neighborhood advisory groups, the lack of followthrough in program implementation by nonprofit organizations that had committed to providing services, and the difficulty in recruiting adequate numbers of community volunteers and in-kind assistance to effectively meet the demand for activities at the family resource canters.

INSTITUTIONALIZATION

At the end of the 5-year demonstration period, the family resource centers, the PNPs, and the Healthy Families Fairfax/Healthy Start program were institutionalized into the Prevention Services Program of the Fairfax County DHD. The public awareness and community education components were continued through a grant to DHD by the Freddie Mac Foundation. The specific goals of this grant were to increase community awareness of factors that weaken family stability; reduce family isolation and stimulate community support networks; strengthen parenting skills and self-esteem in children, adolescents, and adults; and promote family self-sufficiency.

CONCLUSION

Families First in Fairfax struggled through several years of programmatic and staffing changes during the 5-year demonstration period but ultimately

implemented a variety of activities and programs known to be highly effective in supporting families and preventing child maltreatment. These include the three family resource centers with neighborhood-based programs and decisionmaking, the PNPs, and home visitation services for at-risk families through the Healthy Families Fairfax/ Healthy Start program. Of equal importance is the fact that the development of these programs under the NCCAN grant effectively demonstrated the need for and potential benefits of child abuse prevention strategies, which led the county to institutionalize the primary components of the demonstration model. The minigrant strategy, implemented in Year 4, provided other agencies and organizations working in the county the opportunity to develop and conduct a wide variety of family support programs and prevention activities, which effectively multiplied community involvement in prevention strategies while stimulating innovative approaches for specific populations.

The program demonstrated first-hand what it meant to be comprehensive as well as collaborative. For example, although the original intent of the demonstration project was to address physical child abuse prevention, Families First in Fairfax ultimately ended up serving families experiencing or at risk for other types of abuse such as sexual abuse and emotional abuse.. Staff members related that it was difficult to address a single type of maltreatment when families were experiencing multiple abuse situations.